Public Use Files: FAQs

Where does data in the public use files (PUFs) come from and what is included?

The PUFs include data from the Multi-Dimensional Insurance Data Analytics System (MIDAS). MIDAS serves as a central repository for capturing, organizing, aggregating, and analyzing CMS's Marketplace data for the 36 states using HealthCare.gov (HC.gov) in 2021.

The PUFs also include data reported to CMS for State-based Marketplaces (SBMs). SBMs operate their own Marketplaces, with their own platforms, to conduct eligibility determinations, enrollment, and other related functions. In 2021, these states are California, Colorado, Connecticut, District of Columbia, Idaho, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and Washington. In addition, the state-level PUF includes Basic Health Program (BHP) data from New York and Minnesota. The SBMs submit the data to CMS and verify its accuracy as of the date of publication. Questions about data from SBMs should be directed to those states.

The PUFs contain data on individual Marketplace activity, including health insurance applications, Qualified Health Plan (QHP) selections, and stand-alone dental plan (SADP) selections. They also include demographic characteristics of consumers who made a plan selection.

What are State-based Marketplace-Federal Platforms (SBM-FPs)?

SBM-FPs are State-based Marketplaces that run their own Marketplaces, but use the HC.gov platform for eligibility determinations, enrollment, and other related functions. In 2021, these states are Arkansas, Kentucky, Maine, New Mexico, Oregon, and Virginia.

What is the reporting period for these Open Enrollment PUFs?

For the 36 states using HealthCare.gov (HC.gov), the Health Insurance Marketplace reporting period reflects plan selection and Marketplace activity from November 1, 2020 to December 21, 2020. This includes the original 2021 Open Enrollment Period (OEP) from November 1, 2020 to December 15, 2020 and late Marketplace activity between December 16, 2020 and December 21, 2020.

For the 15 SBM states using their own platforms, the reporting period reflects plan selection and Marketplace activity from the beginning of OE on November 1, 2020 to the end of each SBM's respective OEP and any run-out period. Any renewals processed before November 1, 2020 are also included. Data for each SBM are provided through the following dates: California (1/31/2021), Colorado (1/15/2021, including a run-out period to 1/18/2021), Connecticut (1/15/2021), District of Columbia (2/05/2021), Idaho (12/31/2020), Maryland (12/15/2020), Massachusetts (1/23/2021, including a run-out period to 1/28/2021), Minnesota (12/22/2020), Nevada (1/15/2021), New Jersey (1/31/2021), New York (1/31/2021), Pennsylvania (1/22/2021), Rhode Island (1/23/2021), Vermont (12/15/2020), and Washington (1/15/2021).

Why is the HC.gov reporting period longer than the OEP?

Historically, a run-out period of the HC.gov data occurs after the deadline for coverage beginning January 1st. With the original 2021 OEP ending on December 15, it was necessary to extend the reporting period to include data clean-up and late HC.gov activities after December 15, 2020; these included:

- Plan selections on December 16 from midnight to 5 AM ET, which was the original official end time of the OEP;
- New plan selections for consumers eligible for an in-line plan selection due to Call Center volume around the OE deadline;
- New plan selections for consumers eligible for a special enrollment period;
- Consumer cancellations of 2021 active plan selections or automatic re-enrollments;
- Cleanup cancellations of 2021 automatic re-enrollments that are duplicate active plan selections or are no longer eligible for automatic re-enrollment as a result of late cancellations and terminations of 2020 coverage;
- New automatic re-enrollments for a small group of consumers who were not processed before December 15, 2020; and
- Updates to existing automatic re-enrollments to reflect changes in application information made during Open Enrollment.

Can data in the state-level PUFs be compared across states?

Data are directly comparable between the 36 states using HC.gov. CMS does not validate application and enrollment figures for SBMs using their own platforms, and caution should be used when making comparisons between states using their own platforms as definitions may vary. More detail on differences in metrics for SBMs using their own platform is available in the *Public Use Files Definitions* document.

Can data in these files be compared between years?

In general, metrics have the same or very similar definitions across years for the states that use HC.gov; specific changes from the 2020 files are noted throughout the FAQs.

SBMs also generally follow the same or similar definitions across years, as defined by CMS. Data for certain metrics may vary year-to-year due to changes and clarifications to reporting. Data may also vary between SBMs due to differences in reporting systems. In addition, as SBMs operate under different OEPs, the length of the reporting periods can vary on a yearly basis. Generally, any differences in reporting between years should be ascertained by reviewing the FAQs, definitions, and any additional footnotes provided for each year.

For 2021, the following are some reporting changes that may impact specific data comparisons with previous years. Please note that this list is not exhaustive. For questions regarding the comparability of Plan Year (PY) 2021 SBM metrics to data published in past years, please contact the respective SBM.

- New Jersey and Pennsylvania transitioned from an SBM-FP using the HC.gov platform in PY 2020 to an SBM using its own eligibility and enrollment platform in PY 2021. As a result, New Jersey's and Pennsylvania's PY 2021 data may not be directly comparable to past plan years.
- All SBMs except Idaho implemented a Special Enrollment Period (SEP) in response to the COVID-19 Public Health Emergency (PHE) that allowed uninsured consumers to obtain coverage outside of the OE period.
- The economic downturn due to the COVID-19 PHE resulted in decreased incomes and

coverage shifts between QHPs and Medicaid/CHIP, and BHP in Minnesota and New York. For example, while New York reports a decrease in QHP plan selections for PY 2021 in comparison to last year, its BHP enrollment increased substantially for PY 2021 in comparison to last year.

- State implementation of the CMS COVID-19 PHE policy that prohibits termination of individuals enrolled in Medicaid as of March 18, 2020 decreased potential movement of consumers between Medicaid and QHPs during OE.
- California implemented a new state subsidy program in PY 2020, which included a program to help middle-income consumers whose expected household income is up to 600% of the FPL afford coverage; the new state subsidy program resulted in an increase in new consumers last year.

Does this data change over time?

The Marketplaces are dynamic and change on a daily basis as consumers sign up for new coverage or end their current coverage. Data were pulled from MIDAS for the 36 states that use HC.gov as of December 21, 2020. Data for the SBMs using their own platforms were pulled as of the end date of each state's respective OEP or run-out period.

Are all data elements available for every file?

We include data requested and reported to CMS for the SBMs. Data for certain metrics are not provided in the PUFs for these SBMs due to differences in SBM reporting systems or because the data elements were not collected by CMS. Metrics not provided for a SBM for either reason are indicated using "NR".

Application-level data are not included in the county-level file since members on an application may not all be located in the same county and therefore, one application may be associated with multiple counties.

The split of plan selections by rural/non-rural status is not included in the county-level file since rural/non-rural status is determined by ZIP code and could lead to privacy concerns when cross-walked with data at the county-level.

Only a small number of metrics are included in the ZIP-level file due to small cell sizes and the corresponding need to suppress data for privacy protection.

It should be noted that if users open the ZIP-level file or the County-level file using Microsoft Excel, they may truncate the leading zero of a geographic identifier (e.g., County FIPS Code). To avoid truncation, users must open data in other programs such as Notepad.

How does Marketplace application data differ from plan selection data?

Consumers must submit an application to the Marketplace before making a plan selection; the application is where eligibility and financial assistance determinations are made for a QHP, modified adjusted gross income (MAGI) Medicaid, CHIP, or BHP. Multiple consumers can exist on a single application, and a single application can be associated with multiple plan selections. Generally, one application exists per tax household. In addition, not every application goes on to make a plan selection, and, in cases where a family selects multiple policies, it is possible that some of the policies remain active, while others are

canceled or terminated. Application-level data include applications that were created through the automatic re-enrollment process.

Furthermore, since some SBMs are fully integrated with their state's MAGI Medicaid and CHIP programs, their application-level data include applications that were created through the state's MAGI Medicaid or CHIP redetermination process. Further information on those SBMs is provided below and in the *Public Use Files Definitions* document.

How is QHP eligibility determined?

For details on who may qualify for QHP coverage, please refer to https://www.healthcare.gov/quick-guide. Consumers requesting financial assistance may be eligible for Medicaid or CHIP; consumers ultimately determined eligible for Medicaid/CHIP are not eligible to receive financial assistance with a QHP.

How are Medicaid and CHIP eligibility determinations made on the Health Insurance Marketplaces?

States that use HC.gov

HC.gov states may choose to be either a Medicaid/CHIP assessment or Medicaid/CHIP determination state. In assessment states, HC.gov makes an initial assessment of Medicaid and CHIP eligibility based on MAGI, and the state's Medicaid or CHIP office makes the final determination of Medicaid or CHIP eligibility. In determination states, HC.gov makes the final MAGI-based Medicaid and CHIP eligibility determination and transmits eligible applications to the state's Medicaid or CHIP office.

For HC.gov states, Medicaid and CHIP eligibility totals in these files include HC.gov determinations and assessments, regardless of the state Medicaid or CHIP agency's final eligibility determination. In OEPs prior to 2018, applicants in determination states determined eligible for Medicaid or CHIP with an income or residency inconsistency were not counted in the Medicaid and CHIP eligibility totals. For the 2018 and subsequent OEPs, the files include all Medicaid and CHIP determinations, regardless of the existence of an inconsistency. This is consistent with the decision to include Medicaid and CHIP assessments and determinations with citizenship/immigration inconsistencies in previous years. States are responsible for resolving all Medicaid and CHIP inconsistencies and informing the Marketplace if an applicant is ultimately determined ineligible for Medicaid or CHIP.

SBMs that use their own Marketplace platforms

SBMs have different operating systems and procedures for handling QHP and MAGI-based Medicaid and CHIP eligibility determinations, which affect the type of applications the SBM receives and processes, and what is reported in the application, consumer, and eligibility level metrics.

Most SBMs have integrated systems with Medicaid and CHIP and thus determine or assess MAGI-based Medicaid and CHIP eligibility determinations for all new consumers and process eligibility redeterminations for current Medicaid/CHIP consumers. (Due to the COVID-19 PHE, for the 2021 OE, Medicaid/CHIP terminations at redetermination were paused.) The states operating under this model are California, Connecticut, Massachusetts, Maryland, Minnesota, New York, Rhode Island, Vermont, and Washington. Note that California and New York do not report their Medicaid and CHIP eligibility metrics, and Minnesota does not report its Medicaid, CHIP, and BHP redeterminations in the application, consumer or eligibility metrics.

Other SBMs determine or assess MAGI-based Medicaid and CHIP eligibility only when processing new consumer QHP applications received by the Marketplace or through a shared eligibility service with the Medicaid agency, and do not process Medicaid and CHIP redeterminations. Additionally, one SBM (Idaho) does not make MAGI Medicaid and CHIP eligibility determinations, as the Medicaid and CHIP agency processes all applications and financial QHP redeterminations before transferring consumers potentially eligible for a QHP, APTC and/or cost-sharing reductions (CSRs) to the SBM. Further information is provided in the *Public Use Files Definitions* document.

The Medicaid and CHIP eligibility totals in this report do not include non-MAGI-based Medicaid and CHIP eligibility determinations for any states.

The number of applicants determined eligible to enroll in QHP coverage and the number of consumers who are determined or assessed eligible for Medicaid/CHIP do not equal the total number of consumers on applications submitted. Why?

For applications on the HC.gov platform, some applicants may not be eligible for QHP or Medicaid/CHIP. This can occur at the time of application submission when an applicant does not live in the state for which they are applying, or if they do not have an immigration status that qualifies to use the Marketplace. This can also occur at a later date if the Marketplace initially determines or assesses an applicant as Medicaid/CHIP eligible, but a state subsequently determines that the applicant is not eligible. In the latter case, the Marketplace does not automatically grant QHP eligibility.

Applicants using the HC.gov platform can also be eligible for both QHP coverage and Medicaid/CHIP. This can occur when the Marketplace initially determines the applicant QHP eligible, but the applicant requests that the application be transferred to the state for a full Medicaid/CHIP determination. If the state subsequently determines the applicant Medicaid/CHIP eligible, the Marketplace does not automatically remove the QHP eligibility.

In SBMs, similar operational processes affect the count of individuals determined eligible to enroll in a QHP and the count of individuals determined or assessed eligible for MAGI Medicaid/CHIP.

What is the HC.gov definition of a plan selection?

The plan selection count is the number of unique consumers with a non-canceled medical plan selection as of December 21, 2020. This includes consumers who selected a 2021 medical plan, were automatically re-enrolled into a 2021 medical plan, or were placed into a suggested alternate 2021 medical plan. Plan selections made through HC.gov during the 2021 OEP generally had start dates of January 1, 2021.

In OEPs prior to 2018, plan selections were defined as consumers with non-canceled March coverage, which was the latest effective date granted for these OEPs. The March coverage requirement ensured that the files were not counting consumers who had ended their coverage before the end of the OEP.

For the 2018 and later OEPs, plan selections are defined as consumers with any non-canceled coverage, since the OEP for states using HC.gov does not extend into the coverage year (i.e., plan selections made during Open Enrollment did not have a start date within the OEP). All plan selections made by consumers using HC.gov during the 2018 and later OEPs generally have start dates of January 1 and therefore, there is no need to count plan selections with March coverage.

How are consumers who are new to the Marketplace differentiated from consumers returning to the Marketplace?

For the 2018 and later OEPs, the files classify HC.gov consumers as returning if they had coverage through December 31 of the previous coverage year; this aligns with the logic HC.gov uses to determine who is eligible for automatic re-enrollment.

This change to using December 31 is not applicable to SBMs, which continue to classify consumers as returning if they had coverage ending on or after November 1 of the previous coverage year. Please see the *Public Use Files Definitions* document for details on how to define new and returning consumers.

How are active re-enrollees who switched plans differentiated from active re-enrollees who stayed in the same plan from 2020 to 2021? How can active re-enrollees switch plans if there is only one issuer offering coverage in their county or ZIP code?

In these files, active re-enrollees are consumers who actively choose a plan other than the plan into which they would have been automatically re-enrolled had they taken no action (Actv_Renrl_Sw). Issuers generally sell more than one plan in each geographic area, and active re-enrollees may switch from one plan to another plan offered by the same issuer.

What does it mean when a consumer is cross-walked into a plan?

If the same plan is available to a consumer for the new plan year, HC.gov will renew the consumer's coverage in that plan. However, not every issuer has the same offerings from year to year in a given county or ZIP code. In HC.gov states, when the same plan is no longer available, the Marketplace automatically re-enrolls consumers into a different plan, as specified by a crosswalk that generally follows the following hierarchy, defined further in 45 CFR 155.335(j):

- If an issuer continues to offer the same product, consumers are cross-walked to a different plan within that product;
- If an issuer continues to offer Marketplace plans but discontinues a certain product, consumers are cross-walked into a different product with the same issuer; and
- If an issuer no longer offers any Marketplace plans, consumers are cross-walked into a suggested alternate plan with a different issuer.

This metric is not tracked by CMS in SBMs since not all SBMs allow for consumers whose product is discontinued or whose issuer no longer offers any Marketplace plans to be automatically re-enrolled in a new plan.

When are automatic re-enrollments counted?

For states using the HC.gov eligibility and enrollment platform, automatic re-enrollments were accounted for in the Final Snapshot column (Fnl_Snpsht). For SBMs, unless otherwise noted, automatic re-enrollments were added to the plan selection counts beginning in Week 1 or in the following SBMs beginning after Week 1: Colorado (Week 5), Connecticut (Week 3), Massachusetts (Week 4), and New York (Week 3). Given the state-level differences, caution should be used when interpreting data in the "Plan Selections by Week" data.

How is a week of enrollment defined?

For states using HC.gov, the enrollment week begins on a Sunday and ends on a Saturday. SBMs define the enrollment week as Sunday to Saturday, except for Rhode Island, which have a reporting period that runs from Monday to Sunday. In addition, for SBMs, Week 1 includes any 2021 renewals processed before November 1, 2020.

What if a consumer returns to the Marketplace and makes a second plan selection during Open Enrollment? How are they counted?

The plan selection and accompanying demographic information for states using HC.gov corresponds to the most current non-canceled plan selection. In this scenario, the second plan selection would supersede the first plan selection in these files as long as the second plan selection was not canceled. Details on SBMs are located in the *Public Use Files Definitions* document.

How are consumers with APTC and/or CSRs counted?

Eligibility for financial assistance is determined on the application; however, not all consumers eligible for advance payment of the premium tax credit (APTC) or CSRs actually receive such financial assistance. Consumers who are APTC-eligible can elect not to use all or part of their APTC, and instead claim their full premium tax credit when filing taxes. Consumers eligible for CSRs generally need to select a silver plan in order to receive these CSRs. These files count consumers as receiving financial assistance when the APTC amount applied to their plan selection is greater than $0 or the plan selection includes CSRs. More information about APTC and CSRs is available at https://www.healthcare.gov/lower-costs/save-on-monthly-premiums.These files use three measures of financial assistance:

- Consumers with APTC and/or CSRs: any consumer with APTC and CSRs, any consumer with only APTC or any consumer with only CSRs;
- Consumers with CSRs: any consumer with CSRs (with or without APTC); and
- Consumers with APTC: any consumer with APTC (with or without CSR).

Details on SBMs are located in the *Public Use Files Definitions* document. Also note that California, Massachusetts, New Jersey, and Vermont provide a "state subsidy wrap" in addition to APTC and CSRs for consumers at specific income levels.

How are average premiums calculated?

In states using HC.gov, the total policy premium for a medical plan is equal to the sum of covered individuals' premiums. Only the first three children, ages 0 to 20 years old, are included in the policy's premium, and additional children have a premium of $0. Average premiums in these files are equal to the average per-person monthly premium on the policy – Calculation 1.

$$Calculation\ 1 = \frac{sum(individual's\ premium)}{total\ consumers}$$

These files contain two measures that calculate the average premium after the APTC is applied -- referred to as the net premium. When APTC is applied to a policy's premium, it is also allocated among policy members using the Federal age curve (available at https://www.cms.gov/CCIIO/Programs-and-

Initiatives/Health-Insurance-Market-Reforms/state-rating.html) as an intermediate calculation step. The first net premium calculation is the average of the difference between an individual's premium and the individual's allocated APTC for all consumers – Calculation 2.

$$Calculation\ 2 = \frac{sum(individual's\ premium\ -\ individual's\ applied\ APTC)}{total\ consumers}$$

The second net premium calculation is the average of the difference between an individual's premium and the individual's allocated APTC for consumers receiving APTC – Calculation 3.

$$Calculation\ 3 = \frac{sum(individual's\ premium\ -\ individual's\ applied\ APTC)}{consumers\ with\ APTC > \$0}$$

Consumers are considered to be receiving APTC if their allocated APTC amount is greater than $0. See the *Public Use Files Definitions* document for more detail.

Please note that SBMs may calculate average APTC and average premium differently than states using HC.gov.

What are CSRs and how are they related to Actuarial Value (AV)?

CSRs are generally available to consumers whose expected household income is between 100% and 250% of the FPL and select a silver plan. More details are available at https://www.healthcare.gov as well as 45 CFR 155.305(g) and 155.350.

The actuarial value, or percentage of total average costs for covered benefits that a plan covers, is higher for a plan with CSRs than a standard plan due to reduced copays, coinsurance values, deductibles, or maximum out of pocket limits. More details are available at 45 CFR 156.135 and 156.420.

Why are some states and counties missing information on Catastrophic and/or Platinum plans?

Not every state or county offers Catastrophic and/or Platinum coverage, these are indicated using a "+".

How is age measured?

For the 36 HC.gov states, age is measured as the difference between January 1, 2021 and the consumer's date of birth. Age is rounded down to the nearest whole number. Details on SBMs are located on the *Public Use Files Definitions* document.

Why have you included consumers not requesting financial assistance as an income category? Why don't you report household incomes lower than 100% of the FPL? Why don't you report household incomes higher than 400% of the FPL?

For the 36 HC.gov states, the application only collects household income data when consumers are requesting financial assistance. Consumers that do not request financial assistance do not enter their household income information, and are classified as "Not Requesting Financial Assistance" in the files. For SBMs, these consumers are classified as "Other/Unknown FPL".

For consumer protection, CMS does not report incomes below 100% FPL or above 400% FPL. These consumers are included in the "Other FPL" category along with consumers who were requesting financial assistance, but may have missing incomes. For HC.gov states, consumers may have missing incomes due to data anomalies in MIDAS or a tax filing status that makes them APTC-ineligible (e.g., married filing separately).

Why don't the FPL metrics match the CSR metrics?

Consumers eligible for CSRs based solely on household income can only receive CSRs if they enroll in silver plans. The CSR metrics represent the number of plan selections with CSRs, not the number of consumers eligible for CSRs. Furthermore, members of federally recognized tribes may receive CSRs at different levels of household income. More information is available at https://www.healthcare.gov/american-indians-alaska-natives/coverage.

How are race and ethnicity defined?

Race and ethnicity are defined using self-reported information collected on the Marketplace application. For states using HC.gov, the count of consumers who selected Hispanic or Latino ethnicity is independent of race. Details on the race and ethnicity groups are located on the *Public Use Files Definitions* document.

Note that for HC.gov states in years prior to 2017, race and ethnicity were reported in a substantially different way, where ethnicity was not independent of race. Details on SBMs are located on the *Public Use Files Definitions* document.

How is rural/non-rural defined?

These files use the Health Resources and Services Administration (HRSA) crosswalk file to determine whether a consumer resides in a rural ZIP code. This file is available at https://www.hrsa.gov/ruralhealth/aboutus/definition/datafiles.html (October 2017 update).

How are stand-alone dental plans (SADP) counted?

Consumers may purchase SADP coverage on the Health Insurance Marketplaces. Pediatric dental benefits are considered essential health benefits (EHBs), and therefore must be available to all children either as part of a medical plan or as a SADP. In HC.gov states, consumers must purchase a medical plan in order to purchase a SADP. If consumers make a dental plan selection for someone age 18 or younger and have APTC leftover after selecting a medical plan, they can apply this APTC towards the child's dental plan premium. More information is available at https://www.healthcare.gov/coverage/dental-coverage. SBMs may have different procedures for dental enrollment. Please refer to the state Marketplace websites for details.

In previous reporting years, the files reported dental plans selections at two levels of coverage – high and low. High plans typically had higher premiums but lower cost sharing, while low plans typically had lower premiums but higher cost sharing.

For 2019 and later coverage years, CMS removed the actuarial value level of coverage standard for SADPs (83 FR 17069, Apr. 17, 2018). This made the report of the selection of high and low dental plans irrelevant, and thus has been removed from the PUF.

What is a BHP Plan?

The Affordable Care Act allowed states the option of creating a BHP to provide coverage to consumers with incomes below 200 percent of the FPL, who are not eligible for Medicaid or CHIP. BHP plans are offered by Minnesota and New York. New York's BHP is known as the Essential Plan and Minnesota's BHP is known as MinnesotaCare. New York and Minnesota include BHP in some application, consumer and eligibility metrics. See the *Public Use Files Definitions* document for details.

New York has also included additional (i.e., new and re-enrollee breakouts) information on consumers with BHP plans. For inquiries about this data, please contact the New York Marketplace.

What does "*" represent in the PUFs?

These files adhere to the CMS cell size suppression policy to protect consumer privacy. This policy stipulates that no cell of 10 or less may be displayed, which may require the use of complimentary cell suppression. Also, no use of percentages or other mathematical formulas may be used if they result in the display of a cell 10 or less.

What does "+" represent in the PUFs?

In the state and county PUFs, catastrophic and platinum metal levels are not offered in all states and counties. The symbol, "+", represents when a state and/ or county does not offer these metal levels.

What does "NR" represent in the PUFs?

NR represents metrics not provided for an SBM because of differences in SBM reporting systems or data elements were not collected by CMS.

How are the data stratified in the State, Metal Level, and Enrollment Status PUF?

The State, Metal Level, and Enrollment Status PUF contains data with stratifications by State, Metal Level, and Enrollment Status. The data are presented by Metal Level, with the following categories: B (Bronze), S (Silver), and G (Gold), for all consumer types. Similarly, the data are also presented according to Enrollment Status, with the following categories: 01-atv (Active Re-Enrollees), 02-aut (Automatic Re-Enrollees), and 03-new (New Enrollees), for consumers with the applicable Metal Levels (Bronze, Silver, and Gold).

What does "N/A" represent in the State, Metal Level, and Enrollment Status PUF?

N/A represents unavailable values for the individual metal level variables, i.e. Ctstrphc (Catastrophic), Brnz (Bronze), Slvr (Silver), Gld (Gold), and Pltnm (Platinum), when the Enrlmt_Stus (Enrollment Status) value is 'All'.

How do I interpret variables that have a value in a decimal format in the OEP State, Metal Level, and Enrollment Status Public Use File?

The 2021 OEP State, Metal Level, and Enrollment Status Public Use File contains variables with values that are a combination of proportions and counts. In this file, total data records (where State_Abrvtn=Total) are presented as counts; whereas, all other records are presented as proportions in a decimal format. For example, in the table extracted from the PUF shown below, we see that for the state of Arizona, 86% (0.86) of consumers in silver plans had APTC or CSR. We see that the "Total" count of HC.gov consumers in a silver plan with APTC or CSR is 4,386,580.

State_Abrvtn	Pltfrm	Metal_Lvl	Enrlmt_Stus	Cnsmr_Wth_APTC_CSR
AZ	HC.gov	S	All	0.86
Total	HC.gov	S	All	4,386,580